Authorization For Release of Protected Health Information

Patient Name: ________________________ Birth Date: ____________
Maiden/Prior Names: ________________________ Current Phone #: ____________
Current Address: ________________________

To be released to or requested from:

☐ Self (address above)
☐ Other:

Agency/Organization ____________ Name/Attention to ____________ Relationship to patient ____________

Phone Number ____________ Fax Number ____________

Street Address ____________ City, State, Zipcode ____________

Via: ☐ Mail ☐ Fax ☐ Pick-up
For treatment team communication only: ☐ Verbal Exchange of Information ☐ Email, Email Address: ____________

I am requesting disclosure of my protected health information for the following purpose:

☐ Continuing Care ☐ Disability Determination ☐ Child Custody ☐ Personal Use
☐ Academic ☐ Legal Investigation ☐ Billing/Insurance ☐ Other: ____________

Dates of Service Requested: ________________________

☐ **I authorize the release of the following information including all records that include any substance use disorder and/or substance use disorder treatment records, or**

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Only the information and records indicated below (check all that apply and /or specific if "Other is checked):

☐ After Care Packet
☐ Psychiatric Evaluation
☐ Discharge Summary
☐ Progress Notes
☐ History & Physical
☐ Lab/Diagnostic Reports
☐ HIV Test Results and AIDS Treatment Records
☐ Other: ____________

This authorization will expire on ____/____/____. (If not indicated, authorization will expire one year from signature date)

Note: This form must be completed in full before signing:

Patient's signature ____________ Date Signed ____________ Legal Guardian signature (if applicable) ____________

Witness signature/Credentials ____________ Date Signed ____________

This authorization is intended to allow Pembroke to release information, both written and verbal, for the specific purpose and life of the release and in the best interest of the patient. This release of information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information (Privacy Standards), 45 CFR 160 and 164, and all federal regulations and interpretive guidelines promulgated there under. Any information protected by Federal Regulations governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2) is prohibited from further disclosure by the recipient without specific authorization for such re-disclosure.

You have the right to revoke this authorization, by written request, at any time. Exceptions to this can be reviewed in the Notice of Privacy Practices. The revocation will not apply to information that has already been released in response to this authorization. Once the above information is disclosed, it may be subject to redisclosure by the recipient and may no longer be protected by federal regulations. Your right to inspect and receive a copy of the information that is to be disclosed. Choosing not to sign this authorization will prevent the above indicated purpose from being achieved. Treatment or payment for services is not conditioned on signing this authorization. A fee may be associated with copying my information in the process of this request.